OCT 1 - 1980 Yen. 546-D GA 1.13: HRD-80-113

BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Honorable Daniel Inouye United States Senate

COMPLETED

ORIGINAL

Extent Of Billings By Nonpsychiatric Specialty Physicians For Mental Health Services Under CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services pays benefits for mental health services provided by both mental health specialists and nonpsychiatric specialty physicians. Mental health services billed by nonpsychiatric specialty physicians amounted to an estimated 4.3 percent of the total mental health services billed and processed by the Office for CHAMPUS during a 3-month period in late 1978. Patients receiving mental health services from nonpsychiatric specialty physicians were generally treated for only a short time.

HRD-80-113
SEPTEMBER 11, 1980

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GAO
United States General Accounting Office
Washington, DC 20548

Human Resources
Division

B-200047

The Honorable Daniel Inouye
United States Senate

Dear Senator Inouye:

This report is in response to your November 28, 1978, request for an indepth study of the "state of the art" of financing for mental health services provided by four categories of providers. In later discussions with your office, we agreed, because of reported figures that physicians with specialties other than psychiatry (hereafter referred to as nonpsychiatric specialty physicians) were providing 30 to 50 percent of all mental health services, to focus our work on identifying the extent to which those physicians were billing for mental health services. We also agreed to concentrate on the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Our analyses of mental health billings processed by the Office for CHAMPUS during a 3-month period in late 1978 showed that nonpsychiatric specialty physicians provided an estimated 4.3 percent of the total mental health services billed. It should be noted, however, that nonpsychiatric specialty physicians may be providing additional mental health services, but not billing them as such. Often a mental disorder diagnosis was given, but the service billed was an office visit.

When nonpsychiatric specialty physicians provided mental health services to CHAMPUS beneficiaries, the services were rendered over fairly short timespans. Most patients received mental health services for less than 1 month, and many received mental health services only once during the 3-month period analyzed. Most patients received services in metropolitan areas, where it might be expected that mental health specialists are practicing.

As discussed with your office, we have reservations about the accuracy and completeness of some of the statistical data contained in this report because of CHAMPUS' inability to extract all of the billing information from its computer tapes. Also, because of many coding errors made by contractors processing claims for CHAMPUS, we had to adjust the overall data extracted from the computer tapes.

The American Medical Association and the American Psychiatric Association generally supported nonpsychiatric specialty physicians providing mental health services. Both groups stated that nonpsychiatric specialty physicians are often in the best position to diagnose and treat mental problems at an early stage. Also, American Medical Association officials emphasized that nonpsychiatric specialty physicians have the necessary training to provide psychotherapy. However, American Psychiatric Association officials expressed reservations about nonpsychiatric specialty physicians with no special training treating seriously ill mental patients. Officials of both Associations hoped that nonpsychiatric specialty physicians would recognize the limits of their education and training and make referrals to mental health specialists when appropriate.

The Director, Office for CHAMPUS, said he is encouraged by the low percentage of billings for mental health services by nonpsychiatric specialty physicians. Detailed information on these matters is included in appendix I.

Sincerely yours,

Gregory J. Ahart
Director

EXTENT OF BILLINGS BY NONPSYCHIATRIC SPECIALTY PHYSICIANS FOR MENTAL HEALTH SERVICES UNDER CHAMPUS

INTRODUCTION

By November 28, 1978, letter, Senator Daniel Inouye requested us to make an indepth study of the "state of the art" of financing for mental health services provided by four categories of providers. (See app. II.) In later discussions with the Senator's office, we agreed, because of reported figures that nonpsychiatric specialty physicians were providing 30 to 50 percent of all mental health services, to focus our work on identifying the extent to which these physicians were billing for mental health services. We also agreed to concentrate on the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) because of its comprehensive mental health benefits.

In performing this assignment, we extracted mental health billing data from CHAMPUS computer tapes by means of specially written programs. We verified its accuracy by examining selected original claim documents that were the source for the computer data. We also reviewed CHAMPUS regulations and policies, obtained information on benefit expenditures for mental health, and interviewed program and medical association officials.

BACKGROUND

CHAMPUS provides financial assistance for medical care provided by civilian professional and institutional providers to dependents of active-duty members, retirees and their dependents, and the dependents of deceased members of the uniformed services. For purposes of CHAMPUS, the uniformed services are defined as the Army, Navy, Marine Corps, Air Force, Coast Guard, Commissioned Corps of the U.S. Public Health Service, and Commissioned Corps of the National Oceanic and Atmospheric Administration.

The program is administered by the Office for the Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS), at Fitzsimons Army Medical Center near Denver, Colorado. OCHAMPUS is a field activity under the policy guidance and direction of the Assistant Secretary of Defense (Health Affairs). OCHAMPUS contracts with private organizations, referred to as fiscal intermediaries, for the processing of medical care claims submitted by beneficiaries and providers. Nine fiscal intermediaries currently process CHAMPUS claims

from the United States and foreign countries. Fiscal intermediaries are responsible for processing claims accurately in accordance with existing regulations, policies, and instructions.

In many respects, CHAMPUS is similar to private health insurance. It differs, however, in one important respect--CHAMPUS beneficiaries do not pay premiums, but help pay only for services used. This means that, for inpatient hospital care, dependents of active-duty members pay either a $25 total or $5 per day, whichever is greater; other beneficiaries pay 25 percent of the total charges. Outpatient care requires payment of a $50 deductible ($100 maximum for a family) each fiscal year, after which dependents of active-duty members pay 20 percent of other charges, and other classes of beneficiaries pay 25 percent. CHAMPUS beneficiaries are also entitled to receive care in uniformed services medical facilities, normally at no cost or at a lesser cost than under CHAMPUS.

CHAMPUS MENTAL HEALTH BENEFITS

CHAMPUS has been a leader among health benefit programs in providing comprehensive mental health benefits on both an inpatient and outpatient basis. Unlike some medical insurance plans, its benefits are not limited by any dollar amount, by the length of inpatient stay, or by the total number of inpatient or outpatient professional visits. CHAMPUS believes that, rather than limiting mental health benefits as other third-party payors have done, benefits can be controlled primarily through utilization and peer review.

CHAMPUS January 1977 regulations, set out specific utilization and peer review requirements for psychiatric care. These requirements relate to review of cases at specified intervals and approvals needed for extended care. In addition, some restrictions were established for specified short periods of care that will be paid for by CHAMPUS. Utilization and peer review requirements and limitations were developed to recognize good medical practices.

Other actions taken in recent years in managing mental health benefits under CHAMPUS have included (1) the development of standards for program participation by residential treatment centers for children and adolescents, (2) a three-part project in conjunction with the National Institute of Mental Health that included development of standards, treatment criteria, and review of mental services, (3) peer review projects in such places as San Diego, California, and Norfolk, Virginia, providing for concurrent review of psychiatric cases, and

(4) contracts with the American Psychiatric and American Psychological Associations that provide for the development of criteria and peer review procedures for retrospective review along with actual review of cases exceeding specified levels by both Associations' members. The criteria and procedures under the latter project have recently been completed, and reviews of long-term hospitalization have begun. Reviews of professional services are planned to begin shortly.

In a September 18, 1979, letter reply to a draft audit report by the Defense Audit Service, the Principal Deputy Assistant Secretary of Defense (Health Affairs) commented on the effectiveness of these and other actions, stating that between 1973 and 1977, total CHAMPUS mental health costs decreased from $91.95 million to $90.20 million while the average costs of national medical care services (as measured by the Consumer Price Index) increased by 10.5 percent annually.

AUTHORIZED MENTAL HEALTH PROVIDERS

To bill on a fee-for-service basis under CHAMPUS, providers of mental health services must be licensed by the local licensing agency for the jurisdiction in which the care is provided. In the absence of licensure, the provider must be certified by or be eligible for membership in the appropriate national or professional association which sets standards for the profession. In addition, the services provided must be within the scope of the license or other legal authorization.

Types of providers who are authorized and most likely to provide mental health services and who can bill on a fee-for-service basis under CHAMPUS include:

--Physicians--doctors of medicine and doctors of osteopathy.

--Clinical psychologists.

--Psychiatric nurses.

The category of physicians includes psychiatrists who are either board certified or board eligible.

Clinical psychologists, to provide services independently of a physician's referral, must be either (1) licensed or certified by the jurisdiction in which practicing, have a doctoral degree in clinical psychology and a minimum of 2 years of supervised experience in clinical psychology in a licensed hospital, mental health center, or other appropriate clinical

setting as determined by the Director, OCHAMPUS, or (2) listed in the National Register of Health Service Providers in Psychology, compiled and published by the Council of the National Register of Health Services Providers in Psychology. Clinical psychologists are not authorized to make referrals to paramedical providers.

Psychiatric nurses were authorized as independent providers for the first time by the fiscal year 1980 Defense Appropriations Act. The authorization applies only to fiscal year 1980 for the purpose of conducting a test. An OCHAMPUS official told us that OCHAMPUS believes the authorization allowing psychiatric nurses to bill independently of referral will have negligible effects because many State licensing requirements provide that services of a psychiatric nurse be supervised by a physician.

Other persons are also authorized to provide mental health services. However, to be paid on a fee-for-service basis, a referral must be made by a physician, and he or she must provide ongoing oversight and supervision. The types of professional providers who require a referral and who are likely to provide mental health services are:

--Psychiatric and/or clinical social workers.

--Marriage and family counselors.

To qualify, a marriage and family counselor is required to hold a master's degree in an appropriate behavioral science field or mental health discipline and have extensive clinical experience under approved supervision. Also, if required by the State in which one is practicing, a marriage and family counselor must be licensed or certified.

It is the fiscal intermediaries' responsibility to verify an individual's eligibility as a CHAMPUS provider of mental health services. Once the provider has been verified as eligible, the name or provider number is added to an "authorized provider" computer file. The procedures for verifying eligibility vary among fiscal intermediaries. However, the procedures generally involve checking national publications of licensed providers and State licensing lists, communicating with State licensing boards, and reviewing provider applications.

MENTAL HEALTH PAYMENTS IN RELATION TO TOTAL BENEFITS

CHAMPUS benefit payments for fiscal year 1978 totaled $556.3 million. Benefits paid for mental health services for this same year totaled more than $90 million, or about 16.2 percent of total expenditures. 1/ Mental health outpatient services totaled almost $22.6 million, or 26.7 percent of total outpatient professional services of $84.6 million.

A more complete breakdown of fiscal year 1978 CHAMPUS benefit payments is shown below.

Benefit category	Total payments	Mental health payments	Mental health payments as a percentage of total
	(millions)		
Outpatient professional services	$ 84.6	$22.6	26.7
Inpatient professional services	114.4	6.4	5.6
Hospital	354.2	61.0	17.2
Total inpatient and hospital payments	a/$533.2	$90.0	b/16.3

a/Excludes benefit payments for drugs and handicapped benefits.

b/Mental health payments comprise 16.2 percent of total CHAMPUS benefit payments when all costs are considered.

In comparison to CHAMPUS expenditures for mental health services, the Government-wide Service Benefit Plan 2/ paid about 7 percent of its total benefits in calendar year 1978 for mental health services. Also, payments for mental health

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1/These are the most recent complete cost data available because of OCHAMPUS' cost-accumulation method, which phases costs back into the years when the services were provided.

2/A Federal Employee Health Benefits Plan administered by Blue Cross and Blue Shield.

services under the Medicare program 1/ in that year were about 2.2 percent of total benefit expenditures.

Some reasons that mental health payments in relation to total benefit payments are higher under CHAMPUS than these other programs include the following:

--These other programs place limitations on mental health services that were not included under CHAMPUS, such as a lifetime maximum of $50,000 under supplemental benefits of the Service Benefit Plan.

--Mental health services, unlike many other medical services, are generally not available from uniformed services medical facilities. For services other than mental health, CHAMPUS is normally a supplement to the uniformed services direct medical program, whereas for mental health services it is the primary program.

METHODOLOGY EMPLOYED IN EXTRACTING NONPSYCHIATRIC SPECIALTY PHYSICIAN BILLINGS FROM OCHAMPUS DATA

OCHAMPUS does not regularly maintain separate information on billings for mental health services by physicians without a psychiatric specialty. To obtain this information, we prepared a special computer program to extract the desired information from OCHAMPUS computer tapes. These tapes stored historical payment data taken from computer tapes submitted by the fiscal intermediaries in substantiation of disbursements for program benefits.

We selected mental health billings processed by OCHAMPUS during a 3-month period in late 1978 to obtain a sufficient volume of billings to reflect billing patterns.

To obtain data on all mental services performed during this period, we followed a two-step process. First, all procedures on claims with a mental disorder diagnosis were extracted, along with the specialty code of the provider rendering the service. The purpose of extracting claims by diagnoses, in addition to identifying mental health procedures performed, was to identify procedures that may have been mental health related, but were not identified as such on

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1/The Medicare program, administered by the Social Security Administration, provides health insurance for people age 65 and over.

the billing. Second, to identify mental health procedures that may have been missed in treating data by diagnosis, all mental health procedures without a mental disorder diagnosis were extracted, again with the specialty code of the provider rendering the service.

This two-step process gave us mental health billings by both mental health providers and nonpsychiatric specialty physicians. If a mental health procedure was performed, but the claim did not contain either a mental health diagnosis or a mental health procedure, we were unable to identify it.

From the portion of the overall data that indicated services with mental disorder diagnoses by nonpsychiatric specialty physicians, we drew a statistical sample of 271 claims for detailed review and requested claim documentation including claims history files from the fiscal intermediaries who made the payments. Because the universe of claims with mental health procedures, but without mental health diagnoses, consisted of only 185 claims, we examined them all. The purpose of examining claims was to validate the billing data extracted from the OCHAMPUS computer on claims for billings by nonpsychiatric specialty physicians. We also wanted to obtain more detailed information concerning the services provided.

As a result of our claims examination, we adjusted the universe of billings by nonpsychiatric specialty physicians. The adjustments were necessary because of the many miscodings detected. The billings by nonpsychiatric specialty physicians were then combined with those of the mental health specialty providers to produce the total billings for mental health services.

QUALIFICATIONS ON RESULTS OF ANALYSES

Because of problems with OCHAMPUS computer tapes containing consolidated billing data, we were unable to extract the total mental health claims for the 3-month period analyzed. To illustrate the problems encountered, OCHAMPUS processed 168 vouchers from fiscal intermediaries during September 1978; however, in providing us the data, OCHAMPUS and its automatic data processing contractor were able to extract data from only 55 of the 168 vouchers. Additional attempts to run these and other computer tapes resulted in our extracting about 45 percent of the mental health claims for the 3-month period. OCHAMPUS was unable to extract the other claims because other vouchers processed during the period could not be located on the computer tapes and some tapes were not readable.

Another problem involved the accuracy of the computer data. In verifying its accuracy, we went back to the source of the data, which was the medical claims processed by CHAMPUS fiscal intermediaries. Fifty-eight percent of the claims we analyzed contained coding errors by the fiscal intermediaries that caused the claims to be dropped from the analyses. The reasons for dropping claims were that they:

--Were for services performed by a mental health specialty provider.

--Did not contain a mental health diagnosis.

--Did not contain any mental health procedures.

BILLINGS FOR MENTAL HEALTH SERVICES BY NONPSYCHIATRIC SPECIALTY PHYSICIANS AND MENTAL HEALTH SPECIALISTS

The results of our analyses showed that an estimated 4.3 percent of the mental health procedures billed during a 3-month period in late 1978 were performed by nonpsychiatric specialty physicians and an estimated 95.7 percent of the procedures were performed by mental health specialty providers. The percentages of total mental health services performed by type of provider are shown below.

Specialty	Percent of total mental health procedures billed during the 3-month period
Psychiatrists	69.3
Psychologists	22.0
Nonpsychiatric specialty physicians	4.3
Social workers	4.2
Marriage and family counselors	.2
Total	100.0

In addition to the 4.3 percent of mental health procedures billed by nonpsychiatric specialty physicians, we were unable to determine whether or not a mental health service was provided for many other billed procedures. For example, 78 percent of the procedures included in our sample were billed as being for such services as office visits even though the claims in which the procedures were included contained mental health diagnoses. If all of these procedures were actually mental health services, the percentage of mental health

procedures performed by nonpsychiatric specialty physicians would rise from 4.3 to 19.8 percent.

Our analysis of the mental health billings and patient histories showed that most patients received mental health treatment from nonpsychiatric specialty physicians for a period of less than 1 month.

Of patients whose claims appeared in the sample, 61 percent received care for less than 1 month. In fact, 20 percent received only one-time care, while another 41 percent received care more than once but for less than 1 month. Only 2 percent of the claims in the sample were for patients whose claims histories showed that they received mental health care for more than 12 months.

Patients whose claims appeared in the universe of billings for mental health procedures without a mental disorder diagnosis showed similar patterns in length of treatment. Information on length of the treatment by nonpsychiatric specialty physicians obtained from examination of patient claim histories is shown below.

	Length of treatment						
Type of claim	One-time care	More than once but for less than 1 month	1 to 2 months	3 to 4 months	5 to 6 months	7 to 12 months	More than 12 months
	(percent)						
Claim with a mental health diagnosis	19.5	41.5	17.1	12.1	2.4	4.9	2.4
Claim with a mental health procedure, but no mental diagnosis	23.1	41.0	20.5	5.1	2.6	7.7	0.0

During our review, several persons suggested that a possible reason for nonpsychiatric specialty physicians rendering mental health services is that mental health specialists may not be practicing in areas where mental health services are sought. While this may be the reason for some care by nonpsychiatric specialty physicians, our analyses showed that most mental health services provided by nonpsychiatric specialty physicians were provided in metropolitan areas, where one would expect mental health specialty providers to be practicing. Sample claims from nonpsychiatric specialty physicians with a mental disorder diagnosis showed that 83 percent of the patients received services in standard

metropolitan areas. A standard metropolitan area is generally defined as a city with 50,000 or more inhabitants or a city with at least 25,000 inhabitants, which together with contiguous places, has a combined population of 50,000. Only 17 percent of the patients whose claims appeared in our sample received services in nonmetropolitan areas.

This same pattern of services being provided to CHAMPUS beneficiaries was shown on claims from the universe with mental procedures but no mental disorder diagnoses. Eighty-seven percent of these claims showed that the patients had received services in standard metropolitan areas.

The high percentage of CHAMPUS beneficiaries receiving mental health services from nonpsychiatric specialty physicians in metropolitan areas may not be representative of the general population receiving mental health services from such physicians as a whole, but rather may be more reflective of where CHAMPUS beneficiaries reside.

OCHAMPUS STUDY SHOWING SERVICES PERFORMED BY NONPSYCHIATRIC SPECIALTY PHYSICIANS

A recent OCHAMPUS study made in conjunction with Blue Shield of California, a fiscal intermediary, showed that 1.3 percent of all mental health procedures in California were performed by nonpsychiatric specialty physicians. The period covered by the study was from July 1, 1977, to June 30, 1978. Psychiatrists were shown by the study to be performing 63.5 percent of the mental health procedures, and psychologists, 35.2 percent.

OCHAMPUS officials, commenting as to why this study differed from our results, offered the opinion that California has greater numbers of psychiatrists and psychologists than other areas of the Nation, and this greater availability results in less demand on nonpsychiatric specialty physicians.

VIEWS OF AMERICAN MEDICAL ASSOCIATION AND AMERICAN PSYCHIATRIC ASSOCIATION ON NONPSYCHIATRIC SPECIALTY PHYSICIANS PROVIDING MENTAL HEALTH SERVICES

We met with American Medical Association and American Psychiatric Association representatives to obtain their views on nonpsychiatric specialty physicians providing mental health services. Officials from both Associations stated

that nonpsychiatric specialty physicians are often in the best position to diagnose and provide early treatment for mental conditions. Officials from both groups hoped that nonpsychiatric specialty physicians would recognize the limits of their education and training and make referrals to mental health specialists when appropriate.

American Medical Association officials believe that nonpsychiatric specialty physicians are qualified to provide psychotherapy. They said that the primary care physicians are specifically trained to recognize and treat emotional and nonorganic problems. They also said that many emotional problems are short term, and primary care providers can provide the needed assistance to overcome these temporary emotional crises. They added that primary care physicians are seen by patients who believe they have organic problems; however, upon finding no organic causes for health problems, the physicians must be capable of providing mental health treatment for some of the patients. American Medical Association officials believe that the quality and quantity of mental health care can best be regulated not by legislation, but by effective utilization and peer review.

American Psychiatric Association officials expressed reservations about the effectiveness of nonpsychiatric specialty physicians with no advanced training treating, beyond the diagnostic stages, persons with acute mental conditions, such as schizophrenia.

OCHAMPUS COMMENTS ON OUR STUDY RESULTS

The Director, OCHAMPUS, said that he is encouraged by the low percentage of billings for mental health services by nonpsychiatric specialty physicians. He said this low rate indicates that these billings are not a problem area. The OCHAMPUS medical director stated that the mental health procedures screened included some that were examinations for purposes of diagnosing mental health problems. He said these examination-type procedures are well within the area of competence of nonpsychiatric specialty physicians.

OCHAMPUS officials also pointed out that any inappropriate patterns of mental health delivery by nonpsychiatric physicians should be detected by either utilization review or peer review made by the CHAMPUS fiscal intermediaries. They also mentioned that peer review of long-term cases is starting to be performed under contracts with the American Psychiatric Association and the American Psychological Association.

Regarding miscoded claims and problems with computer tapes (see pp. 7 and 8), OCHAMPUS officials said they and their automatic data processing contractor were working to resolve these problems.

APPENDIX II

DANIEL K. INOUYE
HAWAII

United States Senate
ROOM 442, RUSSELL SENATE BUILDING
WASHINGTON, D.C. 20510
(202) 224-3934

November 28, 1978

Mr. Elmer B. Staats
Comptroller General of the United States
General Accounting Office
Washington, D.C. 20548

Dear Mr. Staats:

I would be interested in learning whether it would be possible for the General Accounting Office to conduct an in-depth study of the "current state of the art" of the financing of mental health services that are delivered by the four traditional disciplines: psychiatry, clinical psychology, psychiatric nursing, and clinical social work.

I am specifically interested in learning the extent to which both our federal and private third-party payers reimburse for these services, the extent to which the various disciplines are "professionally mature" enough to accept the responsibility of independent practice, and the extent to which "medical supervision" is deemed necessary or appropriate.

I have introduced a number of bills during the past several Congresses on behalf of the three non-physician health provider groups and have personally been quite impressed by the extent to which my colleagues in both the House and the Senate are generally enthusiastic about their services.

However, there does seem to be considerable disagreement and confusion as to the "current state of the art", the extent to which mental health benefits result in a direct reduction of physical health care costs, and the extent to which the Department of Health, Education and Welfare might have already made a policy determination to phase out the clinical training programs of these three non-physician disciplines.

I look forward to hearing further from you on this possibility.

Aloha,

DANIEL K. INOUYE
United States Senator

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